OGA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Please check all applicable boxes and complete any blank spaces where information is required.

☐ You have my permission to talk with the following individuals involved with my medical care.

Name: _____ Relationship_____ Phone _____

Name: _____ Relationship_____ Phone _____

Name: _____ Relationship_____ Phone _____

Name: _____ Relationship_____ Phone _____

Name: _____ Relationship_____ Phone _____

☐ You have my permission to leave voicemail messages regarding my medical care and test results.

Confirmation of Phone Number: _____

☐ Other. Please Describe _____

_____

This authorization is in **full force and effect until one year** from ____/____/____ or until_____
(Date) *(List specific event)*

I understand that I have the right to revoke this authorization in writing by sending notification to:

OGA
Attn: Privacy Officer
3520 E. Louise Drive
Meridian, ID 83642
(208) 888-0909

I also understand that when I revoke this authorization, it is not effective to the extent that OGA has already relied on the use or disclosure of the Protected Health Information. I understand the Protected Health Information released prior to this authorization might be re-disclosed by the party who received that information and may no longer be protected by federal or state law.

OGA will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure. I understand that I have a right to inspect or copy the protected health information to be used or disclosed. I understand that I have a right to refuse to sign this authorization.

Patient Name:_____ Patient DOB: _____

Patient Signature: _____ Date: _____

Parent or Guardian Name (if Patient is a Minor): _____ Parent/Guardian DOB: _____

Parent or Guardian Signature: _____ Date: _____